K. PARTICIPATION

WAC 388-513-1380 Determining a client's participation in the cost of care for long-term care (LTC) services.

This rule describes how the department allocates income and excess resources when determining participation in the cost of care (in the post-eligibility process). The department applies rules described in WAC 388-513-1315 to define which income and resources must be used in this process.

(1) For a client receiving institutional or hospice services in a medical facility, the department applies all subsections of this rule.

(2) For a client receiving waivered services at home or in an alternate living facility, the department applies only those subsections of this rule that are cited in the rules for those programs.

(3) For a client receiving hospice services at home, the department applies rules used for the community options program entry system (COPES).

(4) Excess resources are reduced in an amount equal to incurred medical expenses (for definition see WAC 388-519-0110(10)) that are not subject to third-party payment and for which the client is liable, including:

(a) Health insurance and Medicare premiums, deductions, and co-insurance charges;

(b) Necessary medical care recognized under state law, but not covered under the state's Medicaid plan; and

(c) The amount of excess resources is limited to the following amounts:

(i) For LTC services provided under the categorically needy (CN) program, the amount described in WAC 388-513-1315(3); or

(ii) For LTC services provided under the medically needy (MN) program, the amount described in WAC 388-513-1395 (2)(a) or (b).

(5) The department allocates nonexcluded income up to a total of the medically needy income level (MNIL) in the following order:

(a) A personal needs allowance (PNA) of:

(i) One hundred sixty dollars for a client living in a state veterans' home;

(ii) Ninety dollars for a veteran or a veteran's surviving spouse, who receives a VA improved pension and does not live in a state veterans' home; or

(iii) Forty-one dollars and sixty-two cents for all other clients in a medical facility.

(b) Federal, state, or local income taxes owed by the client.

(c) Wages for a client who:

(i) Is related to the supplemental security income (SSI) program as described in WAC 388-503-0510(1); and

(ii) Receives the wages as part of a department-approved training or rehabilitative program designed to prepare the client for a less restrictive placement. When determining this deduction employment expenses are not deducted.

(d) Guardianship fees and administrative costs including any attorney fees paid by the guardian, after June 15, 1998, only as allowed by chapter 388-79 WAC.

(6) The department allocates nonexcluded income after deducting amounts described in subsection (5) in the following order:

(a) Income garnisheed for child support:

(i) For the time period covered by the PNA; and

(ii) Not deducted under another provision in the post-eligibility process.

(b) A monthly maintenance needs allowance for the community spouse not to exceed, effective January 1, 2003, two thousand two hundred sixty-seven dollars, unless a greater amount is allocated as described in subsection (8) of this section. The monthly maintenance needs allowance:

(i) Consists of a combined total of both:

(A) An amount added to the community spouse's gross income to provide a total of one thousand five hundred fifteen dollars; and

(B) Excess shelter expenses as specified under subsection (7) of this section; and

(ii) Is allowed only to the extent the client's income is made available to the community spouse.

(c) A monthly maintenance needs amount for each minor or dependent child, dependent parent or dependent sibling of the community or institutionalized spouse who:

(i) Resides with the community spouse, equal to one-third of the amount that one thousand five hundred fifteen dollars exceeds the dependent family member's income.

(ii) Does not reside with the community spouse, equal to the MNIL for the number of dependent family members in the home less the income of the dependent family members.

(iii) Child support received from noncustodial parent is the child's income.

(d) Incurred medical expenses described in subsections (4)(a) and (b) not used to reduce excess resources.

(e) Maintenance of the home of a single client or institutionalized couple:

(i) Up to one hundred percent of the one-person federal poverty level per month;

(ii) Limited to a six-month period;

(iii) When a physician has certified that the client is likely to return to the home within the six-month period; and

(iv) When social services staff documents initial need for the income exemption and reviews the client's circumstances after ninety days.

(7) For the purposes of this section, "excess shelter expenses" means the actual expenses under subsection (7)(b) less the standard shelter allocation under subsection (7)(a). For the purposes of this rule:

(a) The standard shelter allocation is four hundred fifty-five dollars, effective April 1, 2003; and

(b) Shelter expenses are the actual required maintenance expenses for the community spouse's principal residence for:

(i) Rent;

(ii) Mortgage;

(iii) Taxes and insurance;

(iv) Any maintenance care for a condominium or cooperative; and

(v) The food stamp standard utility allowance for four persons, provided the utilities are not included in the maintenance charges for a condominium or cooperative.

(8) The amount allocated to the community spouse may be greater than the amount in subsection (6)(b) only when:

(a) A court enters an order against the client for the support of the community spouse; or

(b) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.

(9) A client who is admitted to a medical facility for ninety days or less and continues to receive full SSI benefits is not required to use the SSI income in the cost of care for medical services. Income allocations are allowed as described in this section from non-SSI income.

CLARIFYING INFORMATION

Participation - the post-eligibility determination

Participation is determined after a client is found eligible for long-term care (LTC) services. This determination sets the amount the client must contribute toward the cost of care. For a client who is married or has dependent family members, this process also determines how much of the client's income is allocated to the spouse and/or family members.

For a client who lives in a medical facility, the department allocates nonexcluded income according to WAC 388-513-1380. For a client who lives at home or in an alternate living facility (ALF) and receives waivered services, the department allocates nonexcluded income according to chapter 388-515 WAC.

Clients who live in an ALF must first contribute to the cost of board and room, which they pay directly to the facility, before participating in the cost of care. Income that remains after deductions for the personal needs allowance and other allocations are taken is the amount the client must participate in the cost of care. Each of the three programs that provides waivered services has specific rules the department follows when determining how much a client pays toward the costs of board and room and medical care.

SSI income

Typically, when an individual enters a medical facility, the Social Security Administration (SSA) reduces the SSI cash payment to $30 per month. The full SSI benefit is continued, if SSA determines the individual's stay in the facility is not likely to exceed three months and the individual has expenses for maintaining a home. When SSA has made such a determination, the full SSI benefit/State supplementary payment (SSP) is continued and is excluded in the post-eligibility process. The SSI/SSP benefit is not excluded, however, when determining the amount a client must contribute toward the cost of board and room when living in an alternate living facility (ALF). Any other income the SSI recipient receives that is not excluded in WAC 388-513-1340 is counted in the post-eligibility determination.

Personal needs allowance (PNA) for clothing, personal items and incidentals (CPI)

The amount deducted for the client's PNA on the first of the month is not reduced during that month when a change occurs in living arrangements. The client retains the full

amount allowed by the specific program and living arrangement for which the client was approved at the beginning of the month. If the PNA amount will increase on the first of the next month because of the change in program services and living arrangement, the current month's amount is supplemented to equal the new amount.

Hospice program

Participation in the cost of care for hospice services received in a medical facility is determined according to WAC 388-513-1380. The client pays their participation amount to the hospice agency. Participation for hospice services received in a client's home is determined according to WAC 388-515-1505 that describes rules used for the Community Options Program Entry System (COPES) program. The client pays their participation amount to the COPES provider.

Hospice eligibility cases are high priority cases. Clients who elect hospice services have a terminal illness with a prognosis of six months or less.

Hospice five-day notification forms

As described in chapter 388-551 WAC, Alternatives to Hospital Services, the hospice agency is required to notify department staff within five working days after a client chooses to receive services from them.

The provider notifies the HCS office for clients in nursing facilities or those receiving services under one of the following programs: COPES, CHORE Services or Medicaid Personal Care Services (administered by AASA).

The hospice agency notifies the CSO for all other clients.

The hospice agency checks for eligibility using the Medicaid electronic verification (MEV) system. If the client is not on assistance, the provider will attach an application for assistance to the notification form. When the client's hospice status changes or eligibility record requires updating, the provider faxes a notification form to the HCS/CSO with the appropriate information. If a client transfers to a different hospice agency, both the old and new providers fax a notification form to the appropriate office with the necessary information.

Veteran’s benefits

Benefits received by veterans and their surviving dependents for Aid and Attendance (A&A), Housebound Allowance (HA) and Unusual Medical Expenses (UME) are

excluded when determining participation in the cost of care with the exception described in WAC 388-513-1340 (33). Such benefits are not counted as income in the post-eligibility process, but become an available resource in the following month if the client does not spend them.

Veterans benefits other than A&A, HA, and UME are counted as income in the month received with the exception of those designated as a dependent allowance. (Dependent allowance benefits are considered to be the dependent's own income.)

Other veteran's benefits include, but are not limited to Compensation, Dependency and Indemnity Compensation (DIC), VA Insurance benefit, Pension, and Improved Pension. When approved, veteran's benefits begin the first day of the month after the month in which the Veterans Affairs (VA) receives the client's application.

A single veteran or widow/er with no dependents who receives a VA service connected compensation may be eligible for VA improved pension benefits. When such a client enters a medical facility other than a state veterans' home and begins receiving Medicaid benefits, VA will reduce that person's benefits to the larger amount of either the service connected compensation or ninety dollars.

Change of circumstances

The reporting requirements for LTC clients are described in WAC 388-418-0005. See **CHANGE OF CIRCUMSTANCES** for additional information. When taking action on a change in the client's circumstances, advance notice is not required in all situations, but adequate notice is always required.

NOTE: A client must receive continued assistance, if all of the following conditions apply:

- Advance notice is not required.
- Adequate notice is mailed less than ten days before the effective date.
- A fair hearing is requested within ten days of the date the letter is mailed.

Advance notice is not required to change a client's participation in the cost of care, since no reduction, suspension, or termination of services will result. A change in the participation amount is not considered an adverse action.

WORKER RESPONSIBILITIES

1. Deduct from the client's nonexcluded income the appropriate amount for the client's personal needs allowance or maintenance needs amount. Use rules that apply to the specific program for which the client is approved when determining the appropriate amount.

2. To reduce excess resources, deduct amounts for medical expenses for which the client is liable.

3. To reduce participation, deduct medical expenses not already used to reduce excess resources. Medical expenses referred to in numbers two and three include, but are not limited to the following:

   - Medicare premium for the first two months; limit this to the first two months, if the client will be approved for the QMB program.
   - Health insurance premiums for the month in which the premium is either billed, due or paid.
   - Medically necessary items not covered by Medicaid. Such expenses include current out-of-pocket expenses and payment for medical bills incurred prior to eligibility for medical assistance.

     NOTE: Do not deduct an amount for medical expenses for which the client was given a reduction of income and/or resources to meet participation or spenddown obligations in the past. It does not matter whether or not the client paid the previous amount.

4. Allocate the income of a client who is married to a community spouse as described in WAC 388-513-1380 (2) (c). Always request an exception to rule (ETR) for allocating the client's income to a former spouse when the Court has ordered a spousal maintenance amount to be paid.

5. When both spouses are receiving LTC services, allocate the income according to the maintenance needs amount provided under the program from which services are received.

6. Example: The amount of nonexcluded income that is allocated from a client in a medical facility who is married to a spouse receiving COPES in the home is limited to the maintenance needs amount provided under the COPES program.

   NOTE: The maximum allocation amount for the maintenance needs of a community spouse includes any excess shelter costs.

7. Allocate the income of a client with a community spouse and a dependent family member by determining the monthly maintenance needs amount in the following way:

   - Subtract nonexcluded income of the dependent from the family allocation standard.

   - Divide that amount by three.

8. Allocate the income of a client with dependent family members, but no community spouse, by determining the monthly maintenance needs amount in the following way:

   - Subtract the dependents' total nonexcluded income from the MNIL standard for the number of legal dependents living in the home.

9. For all LTC services, send service providers and facilities an award letter in order to bill correctly and to receive the correct amount of participation from the client. Each change in status and/or living arrangements requires an award letter.

10. For a client who chooses to stop receiving hospice services, tell the client to obtain and keep a copy of the "revocation" form from the hospice agency. Most medical providers, including pharmacists, will deny services to a client whose medical card indicates hospice services, since the hospice agency is otherwise responsible for all the client's medical needs.

11. Complete and update as necessary the AREP screen to identify individuals or agencies who need to receive a copy of client notices, e.g., hospice agencies, social workers, case managers, guardians, authorized representatives, and protective payees.

12. When a client changes providers or facilities during the month, the participation amount may need to be split between the two. Assign any participation amount the client does not owe the first provider or facility to the second one.

13. Treat hospice revocation or discharge like any other change from one nursing facility to another.

14. Since excluded income amounts can sometimes be quite high, consider the amount excluded in terms of how soon the client's resources may exceed the resource standard. Establish a “tickler” to review resources periodically.

15. When changes in the participation amount are made and confirmed within ACES, the system automatically generates a notice to the client/ representative. Since some notices do not contain enough information, add sufficient freeform text to explain what changes are being made and the reason for them. If appropriate, suppress the notice and generate a letter to replace the notice. Situations for which a new notice and letter are appropriate include, but are not limited to the following:

    - Correct a previous award letter/notice.
    - Make a retroactive change per a fair hearing decision.
    - Make a change in participation per a court order.
    - Make a change in the Health insurance premium that is paid quarterly.
    - The beginning date of hospice care
    - A change in hospice agencies
    - Client chooses to stop receiving hospice services
    - Client enters a medical facility for non-respite care
    - Client leaves a facility or dies

16. When a client dies, review the participation amount assigned in the current award letter. Determine the actual cost of care for services provided using the daily department-contracted rate. If the client's cost of care is less than the participation amount, send an amended award letter that equates the participation amount with the actual cost of care. If the client's cost of care is more than the participation amount, do not change the amount before closing the case.

17. When a client loses institutional status e.g., is no longer eligible for COPES, redetermine the client's eligibility for noninstitutional medical in the following way:

    - Use information in the case record (ACES) unless you need further verification. If a client was CN eligible before losing COPES eligibility, continue CN until you have redetermined the client's eligibility.

    - If the client remains eligible for medical care, change the appropriate ACES screens, complete and send the client a new award letter through the ACES system.

18. Follow necessary supplemental accommodation (NSA) procedures described in chapter 388-200 WAC when appropriate.